Baltimore Life's Silver Guard®
Paper Application and Underwriting Process

While most of Baltimore Life's Silver Guard® applications are written using IN*Speed*®, an innovative point-of-sale application and underwriting process, Silver Guard can also be written using a paper application. An in-bound point-of-sale telephone verification is required on all paper applications.

The Decision Process

You will qualify your client by completing application Form 7430-0508 or it's state specific variation. The applicant can qualify for either Silver Guard I, II, or III based upon the medical questions contained in Part 1 and Part 2 of the application. Make sure that all necessary information is gathered that is required to underwrite and issue the application.

To assist you in classifying a condition, we need to start with the application.

- Part 1 questions do not fall under any time limit.
  - > Questions 1, 2 and 3 are generally "have you ever" questions, and must be answered accordingly.
  - > Question 4 applies to the proposed insured's current condition. A yes answer to any Part 1 question will result in a denial of coverage.
- The lead in to Part 2 of the application states "In the past two (2) years, have you been told or have you had a medical diagnosis, received treatment, had symptom(s) or been hospitalized for any of the following?"
  - > A series of health questions follows. While diagnosis, symptom(s) and hospitalization are easily understood, the concept of treatment may require some clarification.
  - > Treatment applies to any medical condition(s) that has occurred within two years prior to the date of the application.
  - > Medication for certain conditions named on the application must always be considered ongoing and current treatment.
  - > Congestive heart failure, chest pain (angina), Alzheimer's/dementia, insulin dependent diabetes, and chronic renal insufficiency/ failure (kidney disease), though not an exhaustive listing, are major examples of such conditions. People currently taking medication for, or otherwise receiving treatment for these conditions should NEVER answer any health question that relates to their individual condition "No", even if the condition was diagnosed more than two years ago. The appropriate answer to any question relating to these conditions is "Yes".
- Always consult the Prescription Drug List, Form 8420Rx, while completing Part 2 of the application.
- In addition to the application, the following forms are required and can be printed or ordered from the secure area of our website.
  - > Authorization of Release of Health-Releated Information (HIPAA), Form 7699
  - > In Pennsylvania only, Pennsylvania Disclosure, Form 1589
  - > In Maine only, Maine Plan Cost Index, Form 7059 and Maine Preliminary Statement of Policy Cost, Form 7060(ME)
- Other forms may be required such as state-specific replacement forms or the NAIC replacement form, Form 7296-1201-NAIC, if applicable.

The Call Center Details

- Point-of-sale telephone verifications are required on all Silver Guard I, II, and III paper applications.
- After manually completing the application, call toll-free at 877-909-7260. The hours are 10:00 a.m. to 9:00 p.m. Monday through Friday, EASTERN TIME ZONE.
- All telephone verifications must be conducted only with the proposed insured.
- You must identify yourself by name and provide your agent ID number.
- The call center agent will provide you with a call ID number that MUST be written in the comments section of the application. This number allows New Business to quickly match your application with the phone verification file.
- Introduce your client by name and transfer the phone to them.
- After they complete the verbal application, the interview is finished and the call is ended.

If the client only speaks Spanish, an outbound telephone verification should be scheduled with a bilingual Call Center representative.

If an application is taken outside of normal call center hours, please follow the procedures below.

- Instruct the client to call toll-free 877-909-7260 the following business day.
- Advise the client that they will need to
  - > provide their name, social security number, product applied for (Silver Guard I, II, or III), and the name of their agent, and
  - > inform the call center that they are calling for a telephone verification for a Baltimore Life application.
- Please note in the comments section of the application, *"Proposed Insured has been directed to contact call center."*
- You will be notified by Baltimore Life if no phone verification notice has been received within 4 days of receiving the application.

Once the appointment is finished and the decision has been given, please remember to fax your application and all required forms to our New Business center at 866-892-6428 or newbusiness-independentsales@baltlife.com.

Simplified Application

The Baltimore Life Insurance Company
10075 Red Run Boulevard, Owings Mills, Maryland 21117-4871
(800) 628-5433 • www.baltlife.com

Product Applied For _____

☐ Limited Pay – Number of Years _____

PROPOSED INSURED *(First, Initial, Last Name)*

_____

State of Birth _____

Country of Birth _____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

Social Security Number _____

Street Address _____

_____

City, State ZIP _____

Home Telephone _____

Work Telephone _____

E-mail Address _____

Occupation _____

PAYER OF POLICY *if other than Proposed Insured*

_____

Relationship _____

Street Address _____

_____

City, State ZIP _____

Home Telephone _____

OWNER *if other than Proposed Insured*

_____

Relationship _____

Social Security Number _____

Street Address _____

_____

City, State ZIP _____

Home Telephone _____

FACE AMOUNT $ _____

Premium $ _____

Premium Mode ☐ Monthly Bank Draft

If Direct Bill: ☐ Annual ☐ Semi-Annual ☐ Quarterly
(Initial premium must be check or credit card)

Initial Premium paid with application $ _____

☐ Draft Premium Immediately

☐ Charge to Credit Card *(Complete Form 5122)*

☐ Payment by Check

☐ Future Draft Date Request
Draft Date _____

Automatic Premium Loan: ☐ Yes ☐ No

☐ Rider(s)

_____

PRIMARY BENEFICIARY

_____

Relationship _____

CONTINGENT BENEFICIARY

_____

Relationship _____

Part 1

1. Have you been medically diagnosed as having Alzheimer's, or any other form of dementia, or have you been told that you have a life expectancy of 12 months or less? ☐ Yes ☐ No

2. Have you been diagnosed by or received treatment from a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or any other disorder of the immune system, including systemic Lupus, or have you tested positive for exposure to the HIV infection? ☐ Yes ☐ No

3. Have you ever been medically advised to have any organ transplant, are you receiving kidney dialysis, or have you been diagnosed with hepatitis C? ☐ Yes ☐ No

4. Are you currently bedridden, confined to a wheelchair due to chronic illness, in a hospital, living in a nursing home, hospice, assisted living facility, or long-term care facility, or using oxygen or has a doctor recommended that you use oxygen? ☐ Yes ☐ No

(If the answer to any question in Part 1 is "Yes" then the Proposed Insured is not eligible for any coverage.)

Part 2

In the past two (2) years, have you been told or have you had a medical diagnosis, received treatment, had symptom(s) or been hospitalized for any of the following:

1. Heart attack, congestive heart failure, irregular heartbeat, circulatory disorder, aneurysm, or any other disease or condition of the heart or arteries, have you undergone angioplasty or bypass surgery, or have you used a pacemaker? ☐ Yes ☐ No

2. Uncontrolled high blood pressure, uncontrolled diabetes or blood sugars, diabetic coma, or any diabetes requiring the use of insulin? ☐ Yes ☐ No

3. Internal cancer, melanoma, leukemia, sickle cell anemia, kidney disease, liver disease, cirrhosis, chronic lung disease, chronic obstructive pulmonary disease (COPD), or emphysema? ☐ Yes ☐ No

4. Alcoholism or drug abuse? ☐ Yes ☐ No

5. Stroke, any paralysis, Parkinson's, mental retardation, psychosis, suicide attempt, disease or disorder of the brain, or any condition affecting or relating to circulation to the brain? ☐ Yes ☐ No

Part 3

1. Within the last two years, have you had an application for life or health insurance declined, postponed, modified, or refused for any reason, or have you been convicted of a felony or incarcerated? ☐ Yes ☐ No

2. Have you used tobacco products in any form in the last 12 months? ☐ Yes ☐ No

Comments:

REPLACEMENTS:

1. Do you have existing life insurance or annuities currently in force or pending with this or any other company? ☐ Yes ☐ No

2. Will this policy, if issued, replace or modify life insurance or annuities in this or any other company? ☐ Yes ☐ No

If either question is answered "Yes," provide the following information:

Policy # Company Name Replacing Yes or No

_____

_____

_____

PLEASE READ AND SIGN:

I understand that if I provide any false or incomplete answers, and/or if the health of the Proposed Insured changes before the policy effective date and I don't notify The Baltimore Life Insurance Company (the Company) of such changes, then benefits may be denied or the policy may be rescinded. My policy will not take effect unless the first premium is paid in full and the application is approved by the Company. I understand that no agent is authorized to advise me that an inaccurate answer is acceptable.

When I sign the application, I understand, I am authorizing the MIB Group, Inc. ("MIB"), any medical or medically-related person or facility to provide health and/or treatment information about the proposed Insured to the Company. I understand that such information will be used to determine eligibility for insurance and/or benefits. Any information used will be subject to the Company's Notice of Privacy and Information Practices which is provided with my policy, or upon request. I understand that I may request a copy of this authorization and agree that a photographic copy of this authorization shall be as valid as the original. This authorization shall remain valid for a period of two years and six months from the date it is signed.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

APPLICANT(S) PRE-NOTICE

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure to you of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; the telephone number is (866) 692-6901. The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Application made at _____ (City, State) this _____ (Day) day of _____ (Month), _____ (Year)

_____ Signature of Proposed Insured

_____ Signature of Proposed Owner, if other than Proposed Insured

AGENT'S STATEMENT

1. Have you, the writing agent, personally seen the Proposed Insured? ☐ Yes ☐ No
2. Are you aware of any additional information that may affect our underwriting decision? ☐ Yes ☐ No
3. Based on your knowledge, does the Proposed Insured have existing life insurance or annuities? ☐ Yes ☐ No
4. Do you have knowledge or reason to believe that replacement of existing life insurance or annuities may be involved? ☐ Yes ☐ No
5. If replacement is occurring, do you certify that this replacement is within the guidelines provided by Baltimore Life? ☐ Not Applicable ☐ Yes ☐ No
6. Would you like the policy mailed to the policyowner? ☐ Yes ☐ No

Witness (Licensed Agent): I certify that only advertising previously approved by The Baltimore Life Insurance Company was used in conjunction with this sale, and that copies of all sales materials used in this sale have been left with the applicant. Any electronically presented sales materials will be provided in printed form to the applicant no later than at the time of policy delivery.

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Writing Agent Signature	Printed Name	Date	Writing Agent Code No.

If split commissions apply:

Writing Agent #2 (Printed Name)	Date	Writing Agent Code	% of Commission to be paid
Writing Agent #3 (Printed Name)	Date	Writing Agent Code	% of Commission to be paid

MONTHLY AUTOMATIC CHECK AUTHORIZATION

As a convenience to me, I hereby request and authorize you to issue and charge to my account checks drawn on my account by and payable to the order of The Baltimore Life Insurance Company. I agree that your treatment of each check and your rights thereunder shall be the same as if the check was personally signed by me. If any check is dishonored for any reason, I release you from any liability resulting from the dishonor of the check, even if the dishonor results in cancellation of my insurance or annuity policy. Lastly, I agree that this authorization shall remain in effect until written notice of its termination is provided by me to you or until terminated by the Company.

Name _____ Signature _____

Bank Name _____

City, State, ZIP _____

Name of Accountholder _____

Bank Routing Number _____ Account Number _____
(Must be 9 digits)

Signature EXACTLY as it appears on bank records _____

Form 7430-0508(TX)

CONDITIONAL RECEIPT

Received from _____ The sum of $_____

This receipt is given and accepted with the understanding that the insurance applied for shall go into force when the application is completed, the first premium is paid in full, and the application is approved by the Company while the Proposed Insured's condition of health is unchanged from the date of the application.

Proposed Insured _____ Date _____

Agent _____

THE PREMIUM CHECK MUST BE MADE PAYABLE TO THE BALTIMORE LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Tax Notice and Certification

CERTIFICATION: Under penalties of perjury, I certify that (1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); (2) I am NOT subject to backup withholding because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding; and 3) I am a U.S. person (including a U.S. Resident Alien).

Section 6109 of the Internal Revenue Code requires you to provide your correct tax identification number (TIN) to persons who must file information returns with the IRS to report interest, dividends and certain other income. We may also disclose this information to other countries under a tax treaty to federal and state agencies to enforce federal non-tax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

The IRS does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Printed Name	Social Security Number (TIN)
Signature	Licensed Agent Signature (Witness)

The Baltimore Life Insurance Company
10075 Red Run Boulevard, Owings Mills, Maryland 21117-4871
(800) 628-5433 • www.baltlife.com

The Baltimore Life®
COMPANIES

CREDIT/DEBIT CARD AUTHORIZATION

If you wish to take advantage of the Baltimore Life credit or debit card initial payment feature, please complete all information requested below. Upon approval, your credit or debit card will be billed for the initial premium(s) due as set forth on your application or on your policy(ies). Your total charge(s) will then appear on your monthly credit or debit card statement. You may contact us about this authorization by writing to or calling us at:

The Baltimore Life Insurance Company
Attn: New Business Department
10075 Red Run Boulevard
Owings Mills, MD 21117-4871
(877) 533-2468

I AUTHORIZE BALTIMORE LIFE TO AUTOMATICALLY BILL THE CREDIT OR DEBIT CARD LISTED AS SPECIFIED BELOW:

Bill my credit or debit card an amount of $_____.

NAME(S) OF APPLICANT(S) OR INSURED(S)

_____

_____

_____

YOUR BALTIMORE LIFE POLICY NUMBER(S) *(if known)*

_____

_____

_____

CREDIT/DEBIT CARD ACCOUNT

_____
NAME ON CREDIT/DEBIT CARD (EXACTLY AS PRINTED)

( ) ( )
_____
HOME PHONE WORK PHONE

_____
BILLING ADDRESS FOR CREDIT/DEBIT CARD (STREET, APT. #)

_____
CITY STATE ZIP

_____
E-MAIL

_____
CREDIT/DEBIT CARD NUMBER EXPIRATION DATE SECURITY CODE

_____
SIGNATURE TODAY'S DATE

TYPE OF CREDIT/DEBIT CARD

- ☐ Visa
- ☐ MasterCard
- ☐ Discover

(Debit cards must contain the Visa, Mastercard, or Discover logo.)

Form 5122 can only be sent via U.S. postal mail, email between the agency office and the Home Office, or transmitted by fax via dial-up or analog telephone line. Please destroy this form once sent or transmitted to the Home Office.

Please print this form in duplicate. Provide a completed copy to the customer and send one to the Home Office.

The Baltimore Life Insurance Company
10075 Red Run Blvd.,Owings Mills,MD 21117-4871 • (800) 628-5433 • www.baltlife.com

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

You have the right to return the policy within 30 days of its delivery and receive an unconditional full refund of all premiums.

_____
Applicant’s Signature

_____ _____
Applicant’s Printed Name Date

_____
Producer’s Signature

_____ _____
Producer’s Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A copy of this form must be provided tot he applicant and a second copy must be provided to the Home Office along with the application.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

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Is this a tax-free exchange? (See your tax advisor.)
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Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

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Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

_____ _____/_____/_____
Printed Name of Proposed Insured Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy benefit manager, pharmacy, medical facility, or other health care provider that has provided payment treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Baltimore Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Baltimore Life Insurance Company may:

1) Underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
2) Obtain reinsurance;
3) Administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) Administer coverage; and
5) Conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to **The Baltimore Life Insurance Company at 10075 Red Run Boulevard, Owings Mills, MD 21117-4871, Attention: Privacy Official.**

I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Baltimore Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself; any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information; My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization; and further, if I refuse to sign this authorization to release my complete medical record, The Baltimore Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Proposed Insured or Personal Representative Date

_____
Personal Representative's Authority or Relationship to Proposed Insured

_____ _____
Signature of Licensed Agent (Witness) Printed Name of Licensed Agent

Please provide one copy to the Home Office and one copy to the Applicant

The Baltimore Life Insurance Company
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Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

_____ _____/_____/_____
Printed Name of Proposed Insured Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy benefit manager, pharmacy, medical facility, or other health care provider that has provided payment treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Baltimore Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Baltimore Life Insurance Company may:

1) Underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
2) Obtain reinsurance;
3) Administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) Administer coverage; and
5) Conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to **The Baltimore Life Insurance Company at 10075 Red Run Boulevard, Owings Mills, MD 21117-4871, Attention: Privacy Official.**

I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Baltimore Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself; any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information; My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization; and further, if I refuse to sign this authorization to release my complete medical record, The Baltimore Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Proposed Insured or Personal Representative Date

_____
Personal Representative's Authority or Relationship to Proposed Insured

_____ _____
Signature of Licensed Agent (Witness) Printed Name of Licensed Agent

Please provide one copy to the Home Office and one copy to the Applicant